

# **Negotiating What Constitutes Depression: Focus Group Conversations in Response to Viewing Direct-to-Consumer Advertisements for Antidepressants**

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## **ABSTRACT**

**Background** Direct-to-consumer (DTC) advertisements for medication communicate a distinct image of illness and have the potential to shape how we understand what constitutes illness.

**Analysis** The purpose of this study was to explore discursive patterns in how women interact with the messages related to depression in DTC television advertisements for antidepressants. We conducted six focus groups of 1 to 2 hours, with 4 to 6 female participants per group. Within each group, participants viewed and discussed 2 to 3 DTC advertisements.

**Conclusions and implications** Using discourse analysis to explore how the women engaged with the messages in the advertisements, we show how participants reclaimed what constitutes “normal” and “depression” and often positioned the ads as falling short in their presentations of these categories.

**Keywords** Antidepressants; Discourse analysis; Advertisement; Depression

## **RÉSUMÉ**

**Contexte** La publicité directe au consommateur (PDC) sur les médicaments véhicule une image particulière de la maladie qui peut infléchir notre avis sur ce qu'est celle-ci.

**Analyse** L'objectif de cette étude était d'explorer des structures discursives relatives à la manière dont les femmes perçoivent les messages sur la dépression communiqués par des PDC sur les antidépresseurs. Pour ce faire, nous avons mené six groupes de discussion d'une à deux heures comptant 4 à 6 femmes par groupe. Au sein de chaque groupe, les participantes ont regardé et commenté 2 ou 3 PDC.

**Conclusion et implications** Nous avons effectué une analyse du discours afin d'explorer la manière dont les femmes interprètent les messages des PDC. Nous montrons comment les participantes se sont accordées sur le sens de « normal » et de « dépression » tout en percevant les PDC comme inadéquats dans leur présentation de ces concepts.

**Mots clés** Antidépresseurs; Analyse du discours; Publicité; Dépression

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Currently, there are two countries—the United States (U.S.) and New Zealand—that allow direct-to-consumer (DTC) advertisements for prescription drugs (Mintzes, 2006). In Canada, the only types of prescription drug advertisements permitted are reminder advertisements (i.e., those in which the medication is mentioned but not what it “treats”) and “disease-oriented or help-seeking advertisements” (i.e., those that do not mention a specific form of treatment, but communicate health information, including promoting discussion with a physician; Mintzes, 2006, p. 1). Although these regulations are in place, various loopholes result in Canadians being exposed to DTC advertisements (Mintzes, 2006). In a study where DTC drug advertisement exposure rates in the U.S. were compared to those in Canada, Mintzes, Barer, Kravitz, Bassett, Lexchin, Kazanjian, Evans, Pan, and Marion (2003) argued that, though the U.S. population experienced higher exposure, Canadians still reported exposure, and exposure was related to more requests for the advertised medication in both populations. Some researchers have indicated that women can be considered a target audience for these types of advertisements (Brownfield, Bernhardt, Phan, Williams, & Parker, 2013), which is unsurprising in the context of advertisements for medications such as antidepressants, since Pratt, Brody, and Gu (2011) have demonstrated that women are more likely to use antidepressants. As such, discussion of DTC advertisements is relevant within a Canadian context, and consideration of how women, in particular, engage with advertisements for antidepressants is especially pertinent.

Although there is evidence that individuals do not consume health messages passively (Lock, 2012), some researchers argue that DTC drug advertisements can impact the public. For example, Singh and Smith (2005) indicated that just under half their sample reported having sought information about a drug after having viewed an advertisement. Further, just under 20 percent of their sample reported having asked their doctor about a brand of medication after having viewed an advertisement, with slightly less than 60 percent of that number reporting physician compliance. Similarly, other researchers have found that DTC drug advertisement spending and/or exposure was associated with increased visits to physicians, including for the purpose of inquiring about, requesting, or attaining a medication (Bell, Taylor, & Kravitz, 2010; Iizuka & Jin, 2005; Joseph, Spake, & Finney, 2008). At the same time, researchers have highlighted that consumers are skeptical or sometimes critical of the information presented in DTC drug advertisements, and that individuals pay varying levels of attention to and have diverse types of engagement with these advertisements (Alperstein, 2014; Arney, Street, & Naik, 2013; Bell et al., 2010; Joseph et al., 2008).

Critics have also argued that the pharmaceutical industry, including through DTC drug advertisements, “disease mongers” and medicalizes (Arney & Menjivar, 2014; Conrad, 1992, 2005; Healy, 2006; Moynihan, Heath, & Henry, 2002), and that it focuses on a biomedical model of illness (Greenslit & Kaptchuk, 2012; Grow, Park, & Han, 2006). Disease mongering and medicalization are two related concepts that foreground how the categories of illness are expanding to include a broadening range of experiences that can be treated medically (see Arney, & Menjivar, 2014; Conrad, 1992, 2005; Healy, 2006; Moynihan, Doran, & Henry, 2008; Moynihan et al., 2002). Focusing on the biomedical construction within advertisements for antidepressants specifically, re-

searchers have shown that exposure to such advertisements can impact perceptions of depression and its treatment (An, Jin, & Brown, 2009). Specifically, An and colleagues (2009) found that individuals who had higher levels of exposure to antidepressant advertisements tended to have more positive perspectives of using antidepressants and positioned these medications as a primary treatment for depression, though this impact was found to be at least partly mediated by prior experience with depression.

Several researchers have explored the impact of the constructions of depression and its treatment in DTC advertisements for antidepressants, though findings have been mixed. For example, Corrigan, Kosyluk, Fokuo, and Park (2014) found that members of the public who were exposed to a Cymbalta (antidepressant) advertisement were “less likely to offer them [individuals with a mental illness] help, more likely to view them as dangerous, and more likely to endorse social avoidance” (p. 797), though the researchers observed an opposite pattern among those with a mental illness. At the same time, Ball, Liang, and Lee (2014) found that, though the advertisements they reviewed did not present overt messages that could undermine stigmatizing misconceptions about mental illness, these ads did present information on prevalence, which could reduce stigma through normalizing the diagnosis of depression.

A biomedical conception of depression provides a dominant cultural discourse through which depression is framed, and it is evident from the discussion above that advertisements for antidepressants tend to reify this model. Exemplifying the cultural availability of this biomedical discourse, Sigurdson and McMullen (2013) showed that, when talking about the controversy of the over- and under-diagnosis of depression and its treatment with antidepressants, individuals often made a distinction between “real” medical depression and normal experiences of distress. Further, these individuals also emphasized the importance of medical treatment for “real” or serious depression. Although some scholars have argued that a biomedical construction of mental illness might help reduce stigma, others have contended that this model does not relate to level of stigma and could even be linked to an increase in stigma as defined, for example, as the amount of preferred social distance from individuals with a mental illness, and “perceptions of dangerousness” (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Pescosolido, Martin, Long, Medina, Phelan, & Link, 2010, p. 1322). Further, many scholars have claimed that the cultural categories of illness have been expanding to encompass a broadening range of experiences, some of which might have previously been considered “normal” (Conrad, 1992, 2005; Healy, 2006; Moynihan et al., 2002, 2008). There is also evidence that a discourse critical of medicalization has entered public talk (Moynihan et al., 2008; Moynihan & Henry, 2006).

As such, the discourses about depression and treatment within DTC antidepressant advertisements, and how the public interacts with these culturally available discourses, are not inconsequential. Many scholars have discussed the content of these advertisements (see An & Kang, 2011; Ball et al., 2014) and have explored how individuals interact with them, but researchers have typically used survey and questionnaire methods, which are valuable, but could be further nuanced through in-depth qualitative study (see Alperstein, 2014; Park, Ju, & Kim, 2014; Wood & Cronley, 2014).

Based on this gap within the literature, the main question of this research project is “How do women negotiate the presentations of depression in DTC televised advertisements for antidepressants?”

## **Methods**

For our study, we conducted semi-structured focus groups with women in Saskatchewan, Canada. Wilkinson (1998) argued that focus groups are ideal for exploring talk in relation to meanings of health and illness and for in-depth discussion. Krueger and Casey (2009) stated that a “focus group presents a more natural environment than that of an individual interview because participants are influencing and influenced by others” (p. 7). Though we do not agree that focus groups are necessarily more “natural,” this interactive component fits well with our emphasis on how presentations of depression are negotiated. Although focus groups can contribute to the researcher(s) having less control in data collection, which can be considered an issue or limitation of this method (see Krueger & Casey, 2009; Wilkinson, 1998), Wilkinson (1998) argued that this lessened control can actually be valuable in a context where one is interested in exploring participants’ language use and meaning construction.

### *Recruitment*

We recruited participants through the use of printed posters, which we placed on bulletin boards at the local university, on outdoor bulletin boards throughout the downtown core, and in some local businesses. We also used online advertisements on the University of Saskatchewan’s announcements and on the community events section of Kijiji. We provided \$20 compensation to each participant.

### *Participants*

After participants communicated interest in taking part in the study, we individually administered (via email or phone) a brief demographic questionnaire (with questions such as age, length of time living in the area). We limited the demographic information we collected to help maintain participant confidentiality, due to the potentially sensitive nature of the topic, and also because we were not interested in aggregating this information to make group-based claims. In total, we recruited 27 participants.

Since some researchers have positioned adult women as a potential target audience of DTC drug advertisements (Brownfield et al., 2013), we recruited only women (18+ years of age). Focus group composition by age was as follows: group 1 (26, 28, 32, 34, 35), group 2 (18, 26, 26, 26, 29), group 3 (24, 24, 25, 26, 27), group 4 (32, 37, 38, 51), group 5 (19, 23, 28), and group 6 (35, 38, 40, 41, 55), with a mean age of 31.2 years and a range of 18 to 55. We offered one set of focus groups to women who were younger, and one set to women who were older in the event that age might be helpful in understanding our data; however, we did not focus on age for the analysis in this article. We executed the age “grouping” in a flexible manner based on the age range of participants who indicated interest in taking part in the study. In addition to this age consideration, we offered the participants pre-set focus group options (usually 2) on a first come, first serve basis until each group was full.

### *Materials*

We chose three advertisements for participants to interact with: one advertisement

each for Cymbalta, Zoloft, and Pristiq. We chose these advertisements based on availability and researcher familiarity with the campaigns as well as their varied content. In a content analysis of DTC prescription drug advertisements on television, Ball and colleagues' (2014) sample included advertisements for Cymbalta, which could indicate the relevance of the advertisement campaign. Further, the Cymbalta advertisement we chose demonstrated multiple individuals in varying contexts as experiencing depression, which provided multiple potential constructions of depression for the participants to interact with. Additionally, in a study in which An and Kang (2011) analyzed print advertisements for stigmatized illnesses over a 10-year period, advertisements for both Cymbalta and Zoloft occurred, which, again, indicates their relevance. Moreover, the Zoloft advertisement we chose is one that has been uniquely associated with antidepressant medication (i.e., through a stylized figure). We included the Pristiq advertisement because we had seen various iterations of it and because it portrayed a woman with depression in a different context (i.e., at work).

In total, the Cymbalta advertisement was approximately one minute 16 seconds long. Discussion of risks and side effects began at 22 seconds and continued until just before the end of the advertisement. The main slogans of the advertisement emphasized that depression hurts. The advertisement started by listing some symptoms of depression. Within the advertisement there were three main scenarios: a woman getting out of bed looking gloomy and dishevelled; a man at a social gathering but not engaging; and a woman sitting in a chair looking very upset, and minimally engaging with her dog. As the discussion of Cymbalta's risks and side effects began, there was a transition in the experiences of the three focal characters; they seemed "happier" and able to "engage" more. The advertisement ended by recommending that the listener consult her or his physician. We used the following link to access the advertisement: <http://www.ispot.tv/ad/7V1E/cymbalta-depression-symptoms>.

The Zoloft advertisement was approximately one minute in length. The discussion of risks and side effects started at about 36 seconds and continued until just before the end of the advertisement. The main character was an oval-shaped white cartoon figure that looked glum and was being followed by a grey cloud raining on it. A blue bird flew around the character chirping, but the character did not interact. Depression was constructed as potentially relating to levels of neurochemicals (i.e., an imbalance), which the medication helped to regulate. This was demonstrated through a visual diagram of neurochemical transmission, though the narrator stated that the sources of depression have not been identified. Following the presence of medication, the cloud started to dissipate, and the cartoon character began jumping forward, smiling, and acknowledging the blue bird. The advertisement again ended with a directive that the listener should consult her or his physician. The Zoloft advertisement can be found at: <https://www.youtube.com/watch?v=twhtzd6gXA>.

Like the Cymbalta ad, the Pristiq advertisement was approximately one minute 16 seconds long. The discussion of risks and side effects started at 35 seconds and continued until near the end of the advertisement. The central character appeared to be an African-American woman working in a shop. The advertisement opened with her describing her depression and how she had to wind herself up frequently (a metaphor

demonstrated through the ad imagery of a windup doll). The advertisement emphasized that depression was biological through the use of a diagram showing how the medication was hypothesized to work on neurochemical transmission. It ended with an emphasis on Pristiq as integral to the woman's getting well (as evidenced by her smiling and working in her shop), and by encouraging the listener to consult her or his physician. The Pristiq advertisement can be found at <http://www.youtube.com/watch?v=uVNZ8ZBP5gY>.

### *Procedures*

This project was approved by the research ethics board of our university. The focus groups took place in a private room in a community centre in a city in the Canadian Prairies. After listening to a verbal overview of the study, participants completed consent forms. As mentioned, all groups were semi-structured, and they were one to two hours in duration. The moderator (CB) used a question guide to encourage initial discussion as well as prompts based on participants' talk. Questions from the guide include the following samples:

- 1 What is your impression of this advertisement?
- 2 What struck you in particular about the advertisement?
- 3 In this advertisement, they show images of individuals with depression before and after treatment. What is your reaction to the depiction of depression before treatment?
- 4 What is your sense of the extent to which this depiction of depression fits your overall perception of depression?
- 5 In this advertisement, the focus is on the individual depicted as suffering from depression despite having a seemingly normal or enjoyable life. What is your reaction to this depiction of depression?

The moderator altered ordering and wording of the questions based on the focus group discussion. If a question was answered before the moderator asked it, the moderator did not ask the question directly, but instead prompted the participants to say more. Group 4 viewed only the Cymbalta and Zoloft advertisements due to time, while all other groups viewed all three advertisements in varying orders. Discussion occurred following each advertisement, and there was a summary discussion at the end of the session.

### *Data collection*

We audio-recorded the focus groups, and a male note-taker recorded the speaking order. We then transcribed all audio-recordings verbatim and used the transcript notation presented by Lafrance (2009; see the Appendix). We removed identifying information and used numbers (1 to 5) to refer to participants. Following each excerpt, we included, in square brackets, the number of the focus group (1 to 6) and the name of the drug in the immediately preceding advertisement that was viewed by the participants (i.e., [1 Cymbalta]).

### **Methodology**

We adopted a social constructionist position, which focuses on the co-constructive, contextual, and flexible nature of meaning, and eschews the notion that there is one

truth that can be accessed (Burr, 1995). This position fit with the method of analysis of our study as well as with our goals, which were to explore talk without evaluation of its “truthfulness.”

Given this position and our research goals and question, our analysis consisted of the approach to discourse analysis presented by Potter and Wetherell (1987), Potter (1996), and Wood and Kroger (2000), in which the performative and constructive nature of talk was emphasized. As such, the questions of “how ... discourse is put together, and what is gained by this construction” (Potter & Wetherell, 1987, p. 160) guided our analysis. We focused on participants’ uses of various discursive devices, such as wording and sentence structure, to explore how language was used and the potential consequences of these uses of language. The analysis consisted of several readings of the transcripts (often while listening to the audio-recording), the search for relevant sections of the transcript that were specific to our research question, and the extraction of these sections for in-depth analysis.

### Analysis/Results

Within the focus groups, the women undermined the claims to depression and “normal” within the advertisements, which opened space for them to stake their own (counter)claims to these categories, which they did both overtly and covertly. In what follows, we delineate how participants used specific discursive devices and resources (e.g., word choice, sentence structure, arguments) to accomplish these moves (see Potter, 1996, for a discussion of the use of discursive devices to undermine and defend claims). We demonstrate how, through this critical engagement with the advertisements, the women reclaimed normal, reclaimed depression, and demonstrated caution in defence of their claims, which also introduced ambiguity in relation to the definitions of what constitutes normal and depression.

#### *Reclaiming normal*

The implied claims to normal made by the advertisements were often troubled and undermined by the women through various linguistic resources. For example, the women both directly and indirectly constructed ways the advertisements blur the line between normal and pathological. We deduce our reference to “normal” from the participants’ discursive positioning(s) of the categories they were constructing as general or common. Specifically, the women made reference to grief and sadness, stress, general hurting, lacking energy, feeling bad, or a general lack of productivity, which they often downplayed or trivialized in a way that emphasized their normalcy. By doing so, they reclaimed “normal” from the risk of being positioned as pathological through the advertisement’s claims.

In this excerpt, rather than simply saying that the experience in the advertisement does not warrant antidepressants, the participants discuss a normalized way that the experience could be treated.

CB: [...] *How does that **metaphor**: [of the windup doll] for depression kind of fit with how you understand depression, kind of thing.*

1: it doesn’t fit for me at **a:ll**:, like it— it **really** doesn’t, I think that’s— that’s r— be **somethin:g**: you would give if you’re advertising those

24-hour energy drinks or whatever they are, you know what I mean [3: ((laughs))], like kind of like you are just **tired** and don't want to [3: yeah]— but for **depression** it is **no:t**, it's— **yeah, right!**— =

3: = like you don't have **energy and**— or you don't **want** to do something then you have to **make** yourself to do something [1: yeah:], it's like winding up, you just ((someone laughs)) [1: yeah] like, ok, I have to clean up my **house** [1: yeah ((laughs))], ok ((laughs)) I just have to **go** and **do** that.

1: you don't need an **antidepressant**, you need a cup of **coffee**, like ((laughs)) it's just, I don't know ... out of touch from what **I** would think. [5 Pristiq].

Here, we see an instance in which the participants strengthened their claims, including to normal, through collaboration and consensus. For example, they did not directly refute each other's claims, but worked together in constructing a joint claim to normal.

On several occasions the participants communicated that the advertisement did not fit with how they viewed depression (and through contrast, "normal"). Note the use of extrematization ("using the extreme points on relevant descriptive dimensions" [Potter, 1996, p. 187]) and emphasis to express a lack of "fit" of the presentation in the advertisement and the participants' constructions: "It doesn't ... at **a:ll**;" "out of touch," and "**really** doesn't." The disconnection between the representation of depression in the advertisement and the participants' accounts set the tone for the subsequent reclaiming of "normal."

A clear positioning of the experiences (i.e., a lack of energy) as "normal" is evident through the women's references to how the experiences could be addressed (e.g., with a cup of coffee). It can be assumed that this reference to normalized and minimized treatments by the women implies the treatment of something common. Further, "not being able to do what you need to do" was positioned by the participants as a reference to choice or something under personal control, which might relate more to character (e.g., laziness) than pathology.

In the next excerpt, the participants specifically reclaim "normal" by discussing a rejection of the medicalization of stress or sadness.

1: I guess a person::? ... u::m who is::— would have some **stressor** or some sort of other, maybe for a **week**, or five days, or he is feeling **sad** for five days, after seeing this thing, he **mi:ght** think that ... he needs to take some **medication**, or he won't **get over** it without the medication? [4: yeah] I— I think that's— that's ... not ... that's not **fa:i:r**—

4: —I think that **should** be included, that [1: yea:h] **time** frame, because there is a **time** frame [1 Cymbalta]

Reference to stress and sadness works to associate the presentation in the advertisement with common experiences (i.e., to normalize it; see Potter, 1996 for a discussion of normalization). Further, saying that it is "not fair" that treatment of sadness and stress would be medicalized emphasizes the distance between experiences that

are constructed by the women as normal versus pathological. Additionally, the participants say that the advertisement positions medication as necessary in the context of such experiences as “sad[ness],” and they are critical of this positioning. It is implied that the advertisement is abnormalizing normal experiences (i.e., through medicalization; see Potter, 1996, for a discussion of abnormalizing). The participants also attempt to undermine the claims in the advertisement by arguing that they do not provide complete information (e.g., on time frame). In doing so, they subtly present (counter)claims about what constitutes normal (i.e., sadness for a few days) and reposition what is presented in the advertisement as normal.

### *Reclaiming depression*

The focus group participants frequently trivialize and downplay the presentations of depression in the advertisements through, for example, claiming that they reflect something like the flu or a cold, sadness, a lack of energy, a lack of productivity, and anxiety, but not depression. In this way, the participants construct the advertisements as falling short in their claims to depression. In contrast to the claims in the advertisements, the women construct their own (counter)claims to depression in an “attempt” to “reclaim” it as severe, uncommon, and serious.

In the following excerpt, the participants engage with the notion of stake (i.e., vested interest; see Potter, 1996) in their rather complex construction of the advertisement.

1: [...] I quite **like** the adverts, but it was quite **va:gu:e**, you know, it didn't sa:y what **level** of depression you have to **be::?** O:r ... you know, so how long the **effects** would last **afterwards**, and...

CB: M: yeah ... anybody **else?**... Kind of your **impression** of uhm: depression **after** treatment, and how it is represented kind of thing?...

3: that if you take this pill it will just go **awa:y** [1: yea:h] [CB: M:], and you will just go **back** to ... a **happy** life of, or whatever, you— [1: a British cup of **tea**] yeah, that it will just— it will just go **awa:y**, that it will just make it go away, kind of **disappear**.

CB: Kind of how does that fit with how **you** perceive kind of antidepressant **treatment** as working kind of thing

1: Really, an— **against** what my perception of it is, yeah [...], I thi— it is certainly advertising it like a flu:, but like it— if you have a co:l:d, you know, it is like you take these tablets and you will be better in five da:y:s:, you know, it— They are advertising it like that, but for me depression is nothing like that, it— it is much more longer ter:m [4 Zolofit]

Though the women critically engage with the advertisement, such as by constructing its messages as vague and not fitting their perception of depression and treatment, participant 1 does indicate that she “likes” the advertisement, at least in some regards. As such, this excerpt demonstrates that, though there is criticism of the messages in the advertisements, conversation within the focus groups is not solely negative toward them. At the same time, the women in this excerpt jointly undermine the advertisement's claims to depression, and (re)claim depression as severe and serious.

Participant 1 starts to undermine the advertisement's claims through constructing them as vague, and through contrasting that the ease of treatment of depression portrayed in the advertisement is literally opposite to or "against" her perception. Nearing the end of the excerpt, we can see the culmination of this critical interaction with a more direct criticism of the advertisement's claims to depression itself, and the production of a more direct (counter)claim by the women. For example, participant 1 makes a comparison between the presentation of depression in the advertisement and the "flu" or a "cold." Having the flu or a cold are medical aberrations from the "healthy body," though relatively common experiences. A cold and the flu also tend to be, in general, fairly banal and easily treated. This ease of treatment is also referenced in the participant's construction of a relatively quick "healing" time. So, the presentation of the dis-ease in the advertisement is positioned by the women as a common experience and, as such, is normalized and minimized (see Potter, 1996, for a discussion of these discursive moves). This reference to a cold and the flu builds on participant 3's criticism of the advertisement's claim—that it portrays an ease of treatment (i.e., the depression just disappears with treatment).

This reference to a cold and the flu becomes particularly relevant when considering that participant 1 states that "depression is nothing like that." Participant 1 uses extrematization (i.e., "nothing like that") to undermine the advertisement's presentation and support a counter-claim, which further builds on her claim that the ease of treatment in the advertisement literally opposes her perception. As such, in contrasting depression and the presentation in the advertisement, the women construct depression as something beyond a cold and the flu, something more serious or severe. Also note participant 1's use of "much more" in reference to "longer term." This reference to quantity in the context of temporality emphasizes the difference in severity between depression and the alternative experiences presented in the advertisement.

The criticizing of the advertisement, and undermining of its claims, is further supported by participant 1's use of the word "advertising." Her use of this word foregrounds the stakes in the presentation of depression and treatment in the advertisement—to sell a product. Citing the potential intentionality in the presentation of depression raises the possibility that the advertisement is not necessarily "unbiased" and opens up space for the participants' (counter)claims.

In this next excerpt, the participants construct the importance of distinguishing depression from sadness, as well as the potential detrimental outcomes of this distinction not being clear.

3: Yeah, I agree. I feel like that's the **education** [1: Mhm], is realizing that depression and **sadness** that we all feel, that **everyone** knows what it's like to feel? They're **different**, they are very **different things**? [CB: M:] ... [...]

CB: Um ... to what extent do you think the ad ... **differentiates**, 'cause you said kind of there is a difference between **sadness** and **depression** kind of thing?

3: I don't feel like it addresses that at all [CB: M:] ... I feel like that's what's **missing**? Is that education piece, is helping people **understand** that

there's a difference, and because I th—I ... I don't know, again, I am kind of being opinionated ((general laugh)), sorry, but I feel like people will **rationalize** to themselves? that this is just **sadness**, and I should just be able to get over this, and then, when the day that they **can't** get out of **bed** because it's **debilitating**, that's when all of a sudden, you know, oh my god, I can't get out of **bed**, I'm stuck, or someone **finds** them at home and they haven't been out of bed for two **weeks**, you know, like, and I feel like some of that's **harmful**? Some of the **mindsets** that are **perpetuated** by something like this? For one thing that it's curable by a **pill**, and for another that it's something we all go through, so just ... you know, I don't know ... find your way **through** it, or, I don't know... I don't know if I am making sense, or just =

1: = Yeah, cause they don't really explain, like, they are like, depression **hurts**, but they don't really explain like what depression would **be** [3: Right], like, I almost want to say clinical **definition**, or like [3: That might help ((laughs))], yeah, like this is kind of **normal**, this **isn't** [3: Mhm]. Like, if you feel **sa::d**, every **day**, you know, and you don't know **why**, that would be more in line with depression than just run-of-the-mill **sadness**. Usually because with **sadness** you have **reason**, where **depression** can be just ... just because = [3 Cymbalta]

The claims to depression in the advertisement are collaboratively undermined by the participants through their arguments about how the advertisement falls short. This collaboration, in the form of agreeing with and elaborating on each other's claims, strengthens the participants' claims. The participants make direct claims to how the advertisements do not make a clear distinction between mental illness and "normal." Additionally, some participants, such as participant 1, use extrematization (e.g., "at all") to emphasize that the advertisement falls short in its presentation of depression.

Furthermore, the presentation in the advertisement is associated, by the participants, with a minimized and normalized experience (i.e., sadness), which they contrast with depression. For example, sadness, beyond being a normalized experience itself, is referred to, by participant 1, as "just run-of-the-mill." "Just" works to downplay or minimize sadness relative to depression, as well as abnormalize depression through contrast. Participant 3 continually makes reference to there being a "clear" difference between depression and sadness, adding strength to participant 1's claims through elaboration and consensus. This difference is also highlighted through the participants' tonal emphasis, direct stating of difference, and specification of the portrayal as "very" different from depression. Through their claiming that the advertisement does not make this distinction clear and constructing individuals who do not acknowledge it as lacking education, the credibility of the advertisement is questioned in a way that allows space for the women to stake their own (counter)claims to depression.

Through the women's juxtaposition of depression with sadness that "we all feel," it can be assumed that they are positioning depression as *not* something we all feel (i.e., as abnormal). Emphasizing that depression is not universally or commonly experienced draws attention to the severity (through rarity) of depression. Further,

through attempting to articulate the difference between sadness and depression, participant 1 cautiously (e.g., through the use of hedges such as “almost,” “kind of”) relies on a medical association (“clinical definition”), which works to support her claims; invoking medical terminology strengthens her (counter)claims, which include reiterating depression as serious.

*Caution in the defence of claims: The introduction of ambiguity*

Although a logical extension of the above analyses might consist of determining the women’s joint definition of “depression” and “normal,” the participants often leave these categories relatively “blurry” and “open,” despite staking claims to them. Structurally, various forms of hedging and vagueness introduce ambiguity into the conversations. For example, the first-person singular is often used by participants in a way that leaves the categories open to alternative accounts. Further, uncertainty is introduced by the women through hesitation, vague statements, and the use of “I don’t know.” In addition, notions of degrees of severity, types of depression, and a comparison between depression and alternative experiences, for example, allow the participants to acknowledge alternative accounts as depression, while simultaneously reclaiming depression as severe, serious, and uncommon. For example, in emphasizing the severity of depression, there is a risk that milder experiences could be excluded from the category of depression. But if one constructs a distinction between mild and severe depression, there is less risk that “mild” experiences will be excluded from depression. At the same time, it should be recognized that these types of claims, though allowing an acknowledgement of “milder” experiences as depression, could downplay and trivialize some depression (i.e., constructing some depression as less serious or severe).

In this next excerpt the participant employs subtle notions of degrees of severity of depression by contrasting the presentation in the advertisement with more “profound” depression.

3: Um ... it was too: **simple** to me for— to be connected to the people that I know [CB: Mm] that have dealt with depression. Um ... and I mean, I—I—the— obviously there is different ... **levels** probably, of depression as well, but [CB: Mm] somebody ... like, whenever I have been around someone who has been **profoundly** depressed, they can’t ... I mean, they—I don’t even think that would **register** as a— it’s like— it’s all-consuming, it is not like it is something that is separate really, it is just [CB: Mm] “This is who I am, this is ... this is the way it is, this is my **reality** right **now**,” so I don’t **know** that, like I said again, I feel like it would be— it is an easier thing for someone to understand that is **not** depressed? if you look at it that way [CB: Mm] um ... I don’t know [6 Zoloff]

While the participant reclaims depression as something serious and “profound” (contrasted with the presentation in the advertisement), she does so without completely rejecting the existence of experiences of depression that might be less severe or “simpler,” or that might match the construction within the advertisement. For example, though the participant notes that the presentation within the advertisement

is “too simple,” and “wouldn’t register” with people she knows who have depression, opening up the presentation to being positioned as not depression, she states, “Obviously there is different ... **levels** probably, of depression.” This reference to the possibility of “levels” of depression works to leave open the potential acknowledgment of a “simpler” or less “profound” experience of depression as still being depression, though the participant seems to simultaneously criticize this form of depression (bordering on refuting the advertisement’s portrayal of depression). As such, this reference to degrees of severity works to introduce vagueness about what depression is and whether the portrayal in the advertisement can be considered depression.

Further, the positioning of “knowledge” as being obtained through close experience with depression leaves open the category of depression to alternative interpretations and also provides category entitlement (see Potter, 1996). For example, in noting “whenever I have been around,” the participant leaves space open for her experience with depression to not fully encompass depression. For example, perhaps people she knows with depression are different when she is not around them. At the same time, this use of vagueness introduces a space for alternative claims to depression to be acknowledged without her claim to depression necessarily being undermined completely. Further, her reference to close personal experience with depression provides a defence of her claims to depression through the mobilization of category entitlement. For example, people who have personal experience with depression, even if not having been depressed themselves, can be seen as more entitled to make claims to depression, since they are not speaking from a complete lack of experience.

## Discussion

The women’s generally critical tone in their engagement with these DTC advertisements is consistent with literature indicating that consumers can be active, skeptical viewers of such ads (Alperstein, 2014; Arney et al., 2013; Bell et al., 2010; Joseph et al., 2008). In addition, it is also quite likely that this critical tone was, in part, a product of our recruitment strategy and our method of data generation. For example, Alperstein (2014) found that “young adults” (those between 18 and 24 years of age) generally “hold decidedly negative attitudes” (p. 242) toward this category of advertising. Although most individuals in our sample fell outside this age range, over half were under the age of 30. In addition, focus groups are a context in which participants often take up and refute each other’s positions; so it is perhaps not surprising that the participants fashioned arguments, some of which were critical of the advertisements.

As we have shown in our analysis, the women’s engagement with the advertisements demonstrates an implied threat to both normal and depression within the advertisements, as well as a potential tension in the discourses surrounding mental illness. Further, though there has been discussion within academia about how these advertisements medicalize experience and therefore expand categories of illness into areas that could be considered “normal” (see Arney et al., 2014), the present research brings to light how the advertisements can be interacted with as if they also threaten the category of depression (i.e., through trivializing it). This notion of the advertisements potentially “threatening” depression is indirectly supported by researchers who have indicated that exposure to some antidepressant advertisements has been associ-

ated with greater stigma of mental illness among the public (Corrigan et al., 2014). Some of the specific stigma-supporting attitudes that individuals endorsed included being more likely to support social avoidance of individuals with a mental illness, and to position them as dangerous. Although Corrigan and colleagues (2014) did not explicitly discuss trivialization, our research indicates that trivialization might also be an important concept to consider when exploring why or how interacting with these advertisements might contribute toward the stigmatizing of mental illness among members of the public. At the same time, Corrigan and colleagues (2014) found that exposure was associated with improved perceptions of people with a mental illness when those who were exposed to the advertisements reported having a mental illness (Corrigan et al., 2014). Through considering the past and present diagnostic status of our participants, we might have further nuanced our analysis.

### *Reclaiming normal*

The women's specific reclaiming of normal could demonstrate the accessibility of discourses of medicalization (e.g., Arney et al., 2014; Conrad, 1992; Moynihan et al., 2002, 2008). Given that notions of medicalization have entered public discourse (Arney et al., 2014; Conrad, 1992, 2005; Moynihan et al., 2002, 2008), it is not surprising that the women would invoke this talk when engaging with the advertisements. Further, as medicalization can be positioned as a form of social control (Conrad, 1992), resistance to the advertisements' medicalizing claims can also work to resist broadening social control, particularly by the pharmaceutical industry and biomedicine in general.

At the same time, the women walked a fine line between reclaiming normal and minimizing experiences of depression. For example, through indicating that the advertisements were portraying normal experiences, the women opened themselves up to accusations that they were trivializing or minimizing others' experiences of depression that fit the advertisements' portrayals. This risk can be seen in some of the women's defensive talk while reclaiming normal and in their use of hedging. Anti-stigma campaigns in Canada emphasize the importance of not trivializing depression (see Canadian Mental Health Association, 2015, and Pathstone Mental Health, 2014, for examples of anti-stigma campaigns in Canada). As such, the women's talk, including their potential resistance to medicalization, could be problematic from the perspective of anti-stigma talk. Further, the potential negative positioning of the speaker, should she be noted as using stigma talk, could bring into question her claims and open them up to criticism or refutation.

### *Reclaiming depression*

There might also be a link between the women's reclaiming of depression and discourses of medicalization, though with a different focus than in the context of reclaiming normal. Specifically, the medicalization within the advertisements (see Arney et al., 2014; Conrad, 1992, 2005) might threaten to trivialize depression. Arguments related to medicalization position the advertisements as expanding the category of mental illness, which arguably invites more individuals to associate their experiences with the illness (see Arney et al., 2014; Conrad, 1992; Moynihan et al., 2002, 2008). Although some scholars speculate that normalizing mental illness could be associated with less

stigma (see Ball et al., 2014), the women's talk indicates how expanding this category could threaten to trivialize depression by lowering the threshold of severity for what constitutes depression, and making diagnoses of depression more common and perhaps subject to charges of questionable validity. This notion of a threat to depression is clarified and poignantly reflected in the following quote from the popular autobiography of a woman's experience with depression, *Prozac Nation* (Wurtzel, 1995). In the epilogue of the autobiography, Wurtzel (1995) stated,

I can't get away from some sense that after years of trying to get people to take depression seriously ... now it has gone beyond the point of recognition as a real problem to become something that appears totally trivial. ... Every so often, I find myself with the urge to make sure people know that ... I am a real sicko, a depressive of a much higher order than all these happy-pill poppers with their low-level sorrow. (pp. 341–342)

Returning to a Canadian context, the women's defending against the risk of trivialization and minimization of depression is in line with some messages in anti-stigma campaigns related to mental illness in Canada, which emphasize avoiding trivializing mental illness (see Bell Canada, 2015; Canadian Mental Health Association, 2015; Pathstone Mental Health, 2014). We do not intend to imply that the women were referencing or had viewed the specific campaigns we highlighted, but do want to suggest parallels in how the women engaged with the medicalizing claims within the advertisements and some anti-stigma talk about mental illness in Canada.

#### *Caution in the defence of claims: The introduction of ambiguity*

This discursive pattern provides evidence of uncertainties surrounding what constitutes mental illness. For example, in light of the availability of medicalizing discourses (see Conrad, 1992; Moynihan et al., 2002, 2008), the line between mental health and illness can be relatively ambiguous and fluid. For example, the word "depression" can be used as both a signifier for everyday experiences of being "down" and as shorthand for major depressive disorder (McMullen & Conway, 2002). This ambiguity also reflects the risky discursive moves the women were making (i.e., possibly being seen as minimizing or trivializing depression while reclaiming normal and depression).

#### **Future directions**

We chose to use the three DTC antidepressant advertisements in this study based, to some extent, on availability. It will be important to explore whether women interact in a similar fashion with other antidepressant advertisements, including those currently being aired. Further, we know very little about how men, either in all-men or mixed-gender focus groups, might negotiate what constitutes depression in these advertisements.

We also recommend undertaking a similar project in which information related to the participants' experience(s) with and views of depression and its treatment, as well as their familiarity with advertisements for antidepressants, is collected and considered. It is quite possible that people might interact differently with such advertisements depending on such experience(s) (see An et al., 2009). Within our focus groups, a few participants informally made evident that they had close experiences with de-

pression and treatment. For example, they talked about knowing someone who had depression, having had depression themselves, or having taken antidepressants. Based on this participant information, and the evidence from the literature that experience with depression might interact with the impact of DTC antidepressant advertisements (An et al., 2009), it is possible that our focus group conversations were shaped, in part, by these experiences.

Similarly, we did not ask participants about their exposure to DTC drug advertisements. Previous research has shown that those who have more exposure to these types of advertisements view the use of antidepressants more positively (An et al., 2009). As such, level of exposure might be implicated in how the women in this study interacted with the advertisements. Future research might benefit from inquiring about level of experience with the advertisements in order to further contextualize how participants interact with and make meaning of them.

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### References

- Alperstein, Neil M. (2014). Awareness of and attitudes towards direct-to-consumer prescription drug advertising among young adults. *Health Marketing Quarterly*, 31, 231–245. doi: 10.1080/07359683.2014.936291
- An, Soontae, Jin, Hyun S., & Brown, Jane D. (2009). Direct-to-consumer antidepressant ads and young adults' beliefs about depression. *Health Marketing Quarterly*, 26, 259–278. doi: 10.1080/07359680903303981
- An, Soontae, & Kang, Hannah. (2011). Stigma-reducing components in direct-to-consumer prescription ads: Onset controllability, offset controllability, and recategorization. *Health Communication*, 26, 468–478. doi: 10.1080/10410236.2011.554169
- Angermeyer, Matthias C., Holzinger, Anita, Carta, Mauro G., & Schomerus, Georg. (2011). Biogenetic explanations and public acceptance of mental illness: Systematic review of population studies. *British Journal of Psychiatry*, 199, 367–372. doi: 10.1192/bjp.bp.110.085563
- Arney, Jennifer, & Menjivar, Cecilia. (2014). Disease mongering in direct-to-consumer advertising and the expansion of the antidepressant market. *Sociological Inquiry*, 84, 519–544. doi: 10.1111/soin.12062
- Arney, Jennifer, Street, Richard L. Jr., & Naik, Aanand D. (2013). Consumers' various and surprising responses to direct-to-consumer advertisements in magazine print. *Patient Preference and Adherence*, 7, 95–102.
- Ball, Jennifer G., Liang, Angie, & Lee, Wei-Na. (2014). Potential for stigma reduction through direct-to-consumer prescription drug advertising: An exploratory content analysis of television commercials. *Journal of Current Issues & Research in Advertising*, 35, 190–208. doi: 10.1080/10641734.2014.900289
- Bell, Robert A., Taylor, Laramie D., & Kravitz, Richard L. (2010). Do antidepressant advertisements educate consumers and promote communication between patients with depression and their physicians? *Patient Education and Counseling*, 81, 245–250. doi: 10.1016/j.pec.2010.01.014
- Bell Canada. (2015). *5 simple ways to help end the stigma around mental illness*. URL: <http://letstalk.bell.ca/en/news/52/bell-lets-talk-the-5-simple-ways-to-help-fight-the-stigma-around-mental-illness> [April 20, 2015].
- Brownfield, Erica D., Bernhardt, Jay M., Phan, Jennifer L., Williams, Mark V., & Parker, Ruth M. (2013). Direct-to-consumer drug advertisements on network television: An exploration of quantity,

- frequency, and placement. *Journal of Health Communication: International Perspectives*, 9, 491–497. doi: 10.1080/10810730490523115
- Burr, Vivien. (1995). *An introduction to social constructionism*. London: Routledge.
- Canadian Mental Health Association. (2015). *Stigma and discrimination*. URL <http://ontario.cmha.ca/documents/stigma-and-discrimination/> [April 20, 2015].
- Conrad, Peter. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209–232.
- Conrad, Peter. (2005). The shifting engines of medicalization. *Journal of Health and Social Behavior*, 46, 3–14.
- Corrigan, Patrick W., Kosyluk, Kristin A., Fokuo, J. Konadu, & Park, Jin H. (2014). How does direct to consumer advertising affect the stigma of mental illness? *Community Mental Health Journal*, 50, 792–799. doi: 10.1007/s10597-014-9698-7
- Greenslit, Nathan P., & Kaptchuk, Ted J. (2012). Antidepressants and advertising: Psychopharmaceuticals in crisis. *Yale Journal of Biology and Medicine*, 85, 153–158.
- Grow, Jean M., Park, Jin S., & Han, Xiaoqi. (2006). ‘Your life is waiting!’: Symbolic meanings in direct-to-consumer antidepressant advertising. *Journal of Communication Inquiry*, 30, 163–188.
- Healy, David. (2006). The latest mania: Selling bipolar disorder. *PLoS Medicine*, 3(4), 1–4. doi: 10.1371/journal.pmed.0030185
- Iizuka, Toshiaki, & Jin, Ginger Z. (2005). The effect of prescription drug advertising on doctor visits. *Journal of Economics and Management Strategy*, 14, 701–727.
- Joseph, Mathew, Spake, Deborah F., & Finney, Zachary. (2008). Consumer attitudes toward pharmaceutical direct-to-consumer advertising: An empirical study and the role of income. *International Journal of Pharmaceutical and Healthcare Marketing*, 2, 117–133. doi: 10.1108/17506120810887916
- Krueger, Richard A., & Casey, Mary Anne. (2009). *Focus groups: A practical guide for applied research* (4th ed.). Thousand Oaks, CA: Sage.
- Lafrance, Michelle L. (2009). *Women and depression: Recovery and resistance*. New York, NY: Routledge.
- Lock, Margaret. (2012). From genetics to postgenomics and the discovery of the new social body. In M.C. Inhorn & E.A. Wentzell (Eds.), *Medical anthropology at the intersection: Histories, activities, and futures* (pp. 129–160). Durham, NC: Duke University Press.
- McMullen, Linda M., & Conway, John B. (2002). Conventional metaphors for depression. In S.R. Fussell (Ed.), *Verbal communication of emotions: Interdisciplinary perspectives* (pp. 167–181). Mahwah, NJ: Lawrence Erlbaum Associates.
- Mintzes, Barbara. (2006). Direct-to-consumer advertising of prescription drugs in Canada: What are the public health implications? *Health Council of Canada: Taking the pulse*. URL: [http://www.healthcouncilcanada.ca/rpt\\_det.php?id=160](http://www.healthcouncilcanada.ca/rpt_det.php?id=160) [April 20, 2015].
- Mintzes, Barbara, Barer, Morris L., Kravitz, Richard L., Bassett, Ken, Lexchin, Joel, Kazanjian, Arminée, Evans, Robert G., Pan, Richard, & Marion, Stephen A. (2003). How does direct-to-consumer advertising (DTCA) affect prescribing? A survey in primary care environments with and without legal DTCA. *Canadian Medical Association Journal*, 169, 405–412.
- Moynihan, Ray, Doran, Evan, & Henry, David. (2008). Disease mongering is now part of the global health debate. *PLoS Medicine*, 5, e106. doi: 10.1371/journal.pmed.0050106
- Moynihan, Ray, Heath, Iona, & Henry, David. (2002). Selling sickness: The pharmaceutical industry and disease mongering. *British Medical Journal*, 324, 886–890.
- Moynihan, Ray, & Henry, David. (2006). The fight against disease mongering: Generating knowledge for action. *PLoS Medicine*, 3, e191. doi: 10.1371/journal.pmed.0030191
- Park, Jin S., Ju, Ilwoo, & Kim, Kenneth E. (2014). Direct-to-consumer antidepressant advertising and consumers’ optimistic bias about the future risk of depression: The moderating role of advertising skepticism. *Health Communication*, 29, 586–597. doi: 10.1080/10410236.2013.785318
- Pathstone Mental Health. (2014). *Top 11 myths about mental illness*. URL: <http://www.mendthemind.ca/stigma/top-11-myths-about-mental-illness> [April 20, 2015].
- Pescosolido, Bernice A., Martin, Jack K., Long, J. Scott, Medina, Tait R., Phelan, Jo C., & Link, Bruce G. (2010). ‘A disease like any other’? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*, 167, 1321–1330.

- Potter, Jonathan. (1996). *Representing reality: Discourse, rhetoric and social construction*. Thousand Oaks, CA: Sage.
- Potter, Jonathan, & Wetherell, Margaret. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage Publications.
- Pratt, Laura, Brody, Debra J., & Gu, Qiuping. (2011). Antidepressant use in persons aged 12 and over: United States, 2005–2008. *NCHS Data Brief*, 76, 1–8. URL: <http://www.cdc.gov/nchs/data/databriefs/db76.pdf> [April 20, 2015].
- Sigurdson, Kristjan J., & McMullen, Linda M. (2013). Talking controversy: Long-term users of anti-depressants and the diagnosis of depression. *Qualitative Research in Psychology*, 10, 428–444.
- Singh, Tanuja, & Smith, Donnaveive. (2005). Direct-to-consumer prescription drug advertising: A study of consumer attitudes and behavioral intentions. *Journal of Consumer Marketing*, 22, 369–378. doi: 10.1108/07363760510631101
- Wilkinson, Sue. (1998). Focus groups in health research: Exploring the meaning of health and illness. *Journal of Health Psychology*, 3, 329–348. doi: 10.1177/135910539800300304
- Wood, Kelly S., & Cronley, Maria L. (2014). Then and now: Examining how consumer communication and attitudes of direct-to-consumer pharmaceutical advertising have changed in the last decade. *Health Communication*, 29, 814–825. doi: 10.1080/10410236.2013.803437
- Wood, Linda A., & Kroger, Rolf O. (2000). *Doing discourse analysis: Methods for studying action in talk and text*. Thousand Oaks, CA: Sage.
- Wurtzel, Elizabeth. (1995). *Prozac nation: Young and depressed in America*. New York, NY: Penguin.

**Appendix: Transcript notation**

Symbol	Indication
<i>CB: What was your impression...</i>	The moderator's speech
We:ll	A word sound was elongated (more colons for further elongation)
<b>Bold font</b>	Emphasis was placed on the word or sound
—	A participant's communication stopped abruptly
(( ))	Enclosed our description of a non-word sound
.	A period is "a stopping fall in tone" (p. 207)
?	"A rising inflection" (p. 207)
!	"An animated or emphatic tone" (p. 207)
2: I would agree with your [assessment 3: yeah, me too,] I would have to agree as well	Square brackets here enclosed times where individuals spoke over each other
[...]	A part of the extract was excluded
...	A pause in speech (more for a longer pause)
= "at the end of a speaker's utterance and at the start of the next utterance"	"The absence of a discernible gap" (p. 206) between their speech "turns"

Source: Adapted from Lafrance (2009)